

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145867	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Alta Rehab at Fairmont		STREET ADDRESS, CITY, STATE, ZIP CODE 5061 North Pulaski Road Chicago, IL 60630	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Discharge Instruction was completed and provided to a resident upon discharge to ensure a safe and effective transition of care. This failure affected 1 (R5) resident reviewed for discharge requirement in the total sample of 12 residents. Findings include: On 09/02/2025 at 12:09pm, V9 (Assistant Administrator) stated when a resident discharges, there is a Discharge Assessment the nurse prints out at the time of discharge. Nursing will print the Discharge Assessment and the resident or family signs the Discharge Assessment. On 09/02/2025 at 12:14pm, this surveyor opened R5's EHR (Electronic Health Record). V9 stated the Discharge Assessment is on the Assessment tab. Upon opening R5's Discharge Instruction on Assessment tab, Sections A and B were highlighted 'Green', and Sections C, D, E and G were not highlighted. V9 stated if the section is completed it will be in 'green'. V9 checked R5's Discharge Instruction and stated his (R5) Discharge Instruction is not yet completed. V9 stated the process remains the same, the facility will open up the Discharge Assessment and IDT (Interdisciplinary Team) complete their part. Based on what is showing on the Discharge Instruction, she (V7 -Social Services Director) did her part, but nursing did not complete their part. The Discharge Instruction should be completed before his discharge; and nursing will be the one printing it and give the Discharge Instruction to the resident or his family member and on this case to (V24-R5 family member). The importance of completing the Discharge Instruction is for the continuity of care because Discharge Instructions include the resident's medications, appointments, and the resident's diet; and instruction for the continuation of care for wherever the resident is discharged to, which is his home. On 09/02/2025 at 12:35pm, V7 (Social Services Director) stated she opened a Discharge Assessment in electronic health record system and completed two sections and nursing department does the rest. Sections A and B are already completed, and Sections C, D, E, F, and G are not completed. 'Section F' was highlighted yellow because she wrote a note that the Durable Medical Equipment are already available in his home where he would be discharged . Nursing is in charge of making sure all the sections on the discharge assessment is completed. The Dietary Section, the Dietary Department can fill out that Section, but nursing also knows the diet order so they can, too, fill out that Section. The importance of completing the Discharge Assessment is for the continuity of care. On 09/03/2025 at 9:57am, V25 (Licensed Practice Nurse) stated she did not remember giving the Discharge Instruction to (R5). She did not remember filling out the Discharge Instruction form for him (R5). V25 stated nobody reminded her to complete the Nursing Sections of the Discharge Instruction. On 09/02/2025 at 1:09pm, V15 (Medical Records/Transportation) stated the facility has discharge papers the resident or the POA (Power of Attorney) signs and she (V15) is responsible for uploading the discharge document to the electronic health record. On 09/02/2025 at 1:10pm, V15 checked R5's electronic health record and stated the discharge paper that is signed by the resident or the POA is still not uploaded. The nurses usually put the discharge paper in a 'scan' box to be uploaded to the system. V15 stated if he (R5) was discharged on 08/14/2025 then she (V15) should have uploaded the discharge paper already because she checks the scan box every other day. On 09/03/2025 at 10:23am, V15 (Medical Records/Transportation) stated she was not able to find the discharge paper for (R5). That she looked at the scan box and there is no document to upload. V15 stated it means the nurse did not print the discharge instruction for him to sign. On 09/03/2025 at 10:51am, V26 (RN-Registered Nurse/Night Shift Supervisor) stated the facility has Discharge Assessment on the 'Assessment' tab in EHR system. The nurse, who will discharge the resident, is expected to complete the Discharge Assessment in EHR system. The night shift nurse assigned to the resident is responsible for completing the Medications Section of the Discharge Assessment. The nurse, who is discharging the resident, should print the completed Discharge Assessment because there is a section on the Discharge Assessment where the resident has to sign. Signing the Discharge Assessment is an acknowledgment that the resident or the POA receives the medication and the discharge instruction. Each section of the Discharge Assessment will turn green once completed. If it did not turn green, it means that section is not completed or answered yet. Discharge Assessment should be completed prior to discharge. A complete Discharge Assessment gives instruction to the resident or family how they will take the medication and the purpose of the medication. It also explains the follow up appointments that are scheduled. If not completed and not given to the resident, the resident may miss the appointments and or may not take the medications appropriately. R5's admission Record documented that R5's diagnoses (include but not limited to)</p>		